Bioethics Scholars moral and legal opinion on Physician-Assisted Suicide (PAS)

Abstract

This review covers the current legal and ethical perspectives of scholars in the field of bioethics concerning physician-assisted suicide (PAS). It covers the development of new arguments for or against PAS that have been posited by various authors. These arguments vary in their interpretation of what constitutes “killing someone” in comparison to what constitutes “letting someone die.” This literature review will cover the opinions of scholars who claim that these distinctions are clear and noticeable, as well as the views of others who believe that no separation should be drawn between voluntary passive euthanasia and voluntary active euthanasia. Besides stating the trends that the discussion has been following, this review predicts where the field will go in the future.

KILLING VS. LETTING DIE

In order to determine whether or not euthanasia is ethical, philosophers and physicians alike have worked to draw a distinction between actively or passively causing a death. This topic was addressed by Jeff McMahan in 1993 when he claimed that the difference between letting a person die and killing them involves the attribution of reason for that person’s near-death state. [1] He argues that if one withdraws aid from another person after causing that person to need aid, one is effectively killing that person. Alternatively, if one withdraws aid after a person was put into a critical state by independent causes, then one is letting that person die. In relation to the physician-assisted suicide (hereafter PAS) argument, this implies that a doctor removing life support would be letting that person die and not killing them unless the doctor caused the patient to need life support in the first place. While this argument attempts to clarify the distinction between actively killing a person and passively letting them die, it does not address the moral value of each case.

Artificial and Natural Life Support

Alternatively, David Shaw strives to lessen the distinction between voluntary passive euthanasia (VPE) and voluntary active euthanasia (VAE). Rather than dividing the two as McMahon does, Shaw claims that removing life support in VPE equates to the provision of lethal injection or similar actions in VAE because both are eliminating the forces that keep a person alive; in the

case of VPE, this force is the artificially applied life support, while in VAE, this force is the very body that a person's mind is trapped within.2 Both the life support and the living body are keeping the person alive against their will, so killing a person's body is similar to removing a person's ventilator or other type of life supporting equipment. Shaw's view supports the use of VAE and VPE by claiming that VAE is simply another form of VPE, a process that is generally accepted more often.

A critic of this view, Hugh McClachlan does not accept the assertion that a person is defined by their mind. 3 He feels that one's desire to commit suicide warrants a doctor's assistance. A doctor's advice does not require the doctor to actively participate in the consequent actions. McClachlan cites an analogous situation, the offering of sex advice from a doctor, as an example of how a doctor can provide suggestions or care without engaging in the implementation of those suggestions. The statement that VPE and VAE are ethically moral is often disputed by the popular opinion that only VPE should be legalized. Essentially, McClachlan does not agree with Shaw's argument that the two forms of euthanasia are morally similar.

PAS Aligning with Proper Palliative Care

Michael Gill proposes an argument that is founded upon similar premises to those provided by Jeff McMahon. He works to confirm the idea that PAS does not violate the ideals of proper end-of-life care from physicians.4 Detractors claim that physical pain should be eliminated if proper palliative care is in place and that psychological pain is not enough to warrant PAS, but Gill disagrees, asserting that the subjectivity of psychological pain, such as hopelessness, can be based in realistic judgments of a person's future well-being. In those cases, it is right for a patient to feel that their death would be preferable to continued or impending suffering. Gill also proposes that not all physical pain can be eradicated with the use of palliative care, so physicians have a right to euthanize patients if the patients request PAS while mentally healthy. In contrast to the previous opinion of McMahon, this approach does not focus on drawing a distinction between active or passive euthanasia, but it does work to prove the permissibility of both actions.[2]

The Harm of Existing

According to David Benatar, determining whether any form of physician-assisted suicide is permissible requires one to compare the harm faced by continued existence with the relief from pain that not existing can provide. 5 The primary proposition of his book, Better Never to Have Been, is that humans are harmed by coming into existence, but they are not harmed if the never come into existence, so preventing humans from coming into existence is preferable. He clarifies that this view does not encourage suicide in all cases by acknowledging the fact that

there is a difference between a continuing existence and preventing existence from occurring. It might be in a person's best interest to continue existing once they exist, but it could also be beneficial for them to cease existing if their life is unbearably bad. Benatar's perspective ultimately supports the argument of Michael Gill that death may be better for a suffering person than a painful, prolonged existence. In this case, physician-assisted suicide is supported on the basis of its benefit to people whose lives are full of enough pain and suffering that death is a more appealing option than life.

Inconclusive Evidence

While many scholars have taken firm stances on how they view PAS as a moral and legal dilemma, others, like Bonnie Steinbock, have remained uncertain due to the diverse mixture of evidence for and against PAS.6 In Steinbock's opinion, the need for PAS is currently "not proven," so continued discussion must take place for some conclusions to be effectively drawn. She acknowledges both sides of the debate, citing the arguments from suffering and from autonomy that Michael Gill supports, but she also considers the other side by referencing religious arguments and the idea of physicians as individuals who heal, rather than hurt, their patients. Steinbeck evaluates several cases of individuals who spent prolonged periods of time suffering through terminal illness. She looks at two patients- one who chose PAS and one who didn't- to analyze the factors contributing to their decisions while offering perspectives that simultaneously support and detract from those who value PAS. Her technique of referencing both sides where she sees fit is one that allows for an unbiased perspective on[3] PAS. Ultimately, she contends that more work needs to be done in this area since case studies of specific individuals' experiences with PAS can't be used as the basis for changing laws.

Taking a less neutral stance in his article "Organized Obfuscation: Advocacy for Physician-Assisted Suicide," Daniel Callahan criticizes those who support euthanasia and physician-assisted suicide for utilizing organized obfuscation, or coordinated efforts to make arguments unclear. He references the Dutch response to a publication in The Hastings Center Report that claimed the Dutch were failing to control the practice of PAS in their country7.

Although it is legal in the country for individuals to request PAS without any terminal illness, the published article claimed that informed consent was not consistently given to patients. In response to this, Dutch supporters of euthanasia stated that the there was a misunderstanding over the process of euthanasia in the Netherlands due to differences in the definition of the term. Callahan also presents the cases of the existing legislation in Oregon and the proposed legislation in Washington. Each piece of legislation implicitly or explicitly states that information collected about clinical decisions that are made may not be inspected by the public, making it seem as if there will not be any public surveys about the effectiveness and safety of each state's program. Callahan, like Steinbock, is skeptical of the evidence provided by proponents

of the view that legalization of PAS is justified. His reasoning, however, is based on the attempts to make ambiguous statements about the information collected from PAS programs while Steinbock is concerned with the moral strength of each argument.

In Steinbock's view, it is unclear whether or not PAS can be justified given the current arguments that both sides have made, but it is clear that the evidence for both sides will progress with a focus on legal rather than moral reasoning.

Conclusion

Ultimately, the current perspectives on the field of PAS are broken into two primary constituent debates- the debate over what constitutes VAE or VPE and the debate over whether these two are compatible with doctor's obligations to their patients. According to the trend of research in the field, it appears that the broader definition of PAS as a process that allows both VAE and VPE will be the future focus of this debate. Because of these definitive considerations, it seems that the discussion will shift a philosophical debate on moral ethics to a focused argument concerning legal philosophy that questions the legitimacy of these applications to those who face terminal illnesses.